a type of medical establishment that I would feel ashamed about.

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1 Strang J, Heathcote S, Watson P. Habit moderation in injecting drug addicts. *Health Trends* 1987;19:16-8.

SIR,—A vein of rich irony suffuses the leading article by Dr John Strang and colleagues. They define those who differ from them as polar opposites and then set themselves up as arbiters even though they are the protagonists who have created the polarisation. No responsible source has advocated maintenance for all, nor indeed do drug takers want that.[1] Where is there evidence that those who do prescribe maintenance do not also offer detoxification, withdrawal, or a host of other alternatives?

The authors' assertions about the "passionate preaching of zealots" also miss the point completely. Most drug users do not see themselves as in need of "treatment" any more than most tobacco users do (J H Willis, Royal College of Psychiatrists meeting, 1986) and the question is how to deal with this majority of drug users and their effects on society. Dr Strang and Professor Ghodse themselves inveigh against prohibition in the latest report of the Royal College of Psychiatrists,[2,3] but if prohibition is ended, as they imply, how are drugs to be controlled?

The empirical picture of drug use demands flexible, pragmatic management. To remain empirical, rigorous evaluation is essential and in the Mersey region this has been carried out.[3] Of a sample of 1019 patients, 9% receive maintenance prescriptions of injectable drugs and a further 25% receive syrup of methadone, subject to dissuasion, health care, advice, and counselling; 51% get no drugs at all. Further studies will judge the outcome of these policies. This is far from "all get maintenance." In contrast, the 55 drug users in Strang's quoted study continued breaking the law and risking their own and others' health using dangerously adulterated illicit drugs, from which only criminals profit. That some patients moderate their habits is the natural history of drug use, but even greater positive findings without the attendant risks can be achieved with maintenance—for example, of Dally's cases all but four reduced their dose and none increased their dose.[4] The drug takers in the study by Gossop *et al*, who agreed to admission for three weeks in a psychiatric unit, were a highly selected group and unrepresentative of drug takers as a whole. Furthermore, they were studied an average of 11 years after they started taking drugs. This suggests they were probably nearing the end of the "addictive set"[5] and may have got better in spite of treatment not because of it. Even so, seven of the 57 failed to complete the inpatient programme, and only 12 of the 57 were drug free at six months and we do not know what has happened to these 12 since. This is better than the spontaneous remission rate of 5% per year but poor considering this was a highly motivated group, ready to give up.

Dr Strang and colleagues are right that general practitioners need to be more involved, but the *Guidelines of Good Clinical Practice* have had the opposite effect: some even feel they have been used as an instrument to arraign doctors for heterodox practice.[6,7] The problem is that the guidelines do not address one of the most salient features of the natural history of addiction: that despite any intervention an addict remains addicted for several years. Maintenance has a place in managing such patients, but no guidance is given on this important tool in reducing harm.

Although maintenance prescribing is not "treatment," it permits rehabilitation; anyway, the distinction between treatment and rehabilitation is arbitrary and can be counterproductive.[8] Whatever policies are pursued evaluation helps establish their bases. Finally, your leader writers create another opposition: who decides treatment, doctor or patient? Why not doctor and patient?

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## Supplies of anti-Rh(D)

SIR,—The policy for administration of Rh(D) immunoglobulin for threatened miscarriage in rhesus negative women was clearly established in 1976 and endorsed in 1981. As far as we are aware, the only dissension in 1981 revolved round the suggestion and practicability of using the Kleihauer test in cases of threatened abortion.

Certainly full implementation of the agreed policy requires that if they have not already done so general practices need to develop ready access to Rh(D) immunoglobulin from their local blood banks, possibly even keeping a small stock themselves if they are to provide an effective domiciliary service. As Dr Deane Collinge says (28 November, p 1415), at its outset this may necessitate short term redistribution of the nation's supply.

Although strenuous efforts are being made to improve supplies of anti-D immunoglobulin, at present there is barely enough for standard prophylaxis as defined. Therefore, it would not be practical for general practices to hold large stocks because much anti-D would then be out of circulation.

None the less, the present supply difficulties should not detract from the longer term aim of providing immunoglobulin nationwide, for miscarriages as well as postnatally and, in time, even antenatally, to keep avoidable Rh(D) sensitisation to a minimum.

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SIR,—Until comparatively recently England and Wales were able to provide enough anti-Rh immunoglobulin for their own needs. The amount of plasma containing anti-Rh collected by the National Blood Transfusion Service has, however, been decreasing, and recently, when most of the anti-D stocks of plasma had to be discarded owing to contamination by plasma donations from a donor who developed a soft tissue sarcoma, the shortage was such that it became necessary to buy anti-Rh immunoglobulin from abroad. Dr J Dean Collinge referred to the effects of that shortage.

Experience at the North London Blood Transfusion Centre indicates that it would be easy to increase the procurement of plasma containing anti-Rh in England and Wales to a self sufficient level. Before the recent shortage arose the north London centre was already providing about 20% of all the plasma containing anti-Rh sent to the Blood Products Laboratory. When it became clear that a national shortage was imminent procurement was increased.

Between December 1986 and May 1987, in screening almost 100 000 donors, 202 with anti-D were found. After explanation of the need for plasma containing anti-Rh about 150 of the subjects agreed to participate. After women of childbearing age had been rejected about 100 subjects were available for restimulation. They were asked to have a blood sample taken by their general practitioner so that the presence of anti-Rh(D) could be confirmed and the red cells tested for S, s, K, $Kp^a$, $Fy^a$, $Fy^b$, $Jk^a$, $Jk^b$, $Le^a$ and $Le^b$.

Blood was received from 66 subjects; for 60 of these accredited donors whose red cells were compatible for the above antigens were available. After detailed explanations 42 of the 60 agreed to receive injections of Rh positive red cells and to undergo plasmapheresis subsequently.

Intravenous injections of up to 1 ml of red cells were given at intervals of not less than two weeks until the level of anti-D exceeded 100 IU/ml (20 μg/ml). Donations of plasma were then obtained every two to three weeks. The total amount of anti-D collected from October 1986 to September 1987 was $69{\cdot}4 \times 10^6$ IU, whereas only $40 \times 10^6$ IU had been collected during 1985.

In October 1985 the anti-D working party of the National Blood Transfusion Service estimated the annual requirement of anti-Rh immunoglobulin for routine postnatal prophylaxis to be $80\,000 \times 500$ IU doses per year—that is, $40 \times 10^6$ IU. When the 250 IU doses required for immunoprophylaxis are taken into account the total annual requirement is estimated to be $54 \times 10^6$ IU. As the yield of anti-D immunoglobulin from plasma is only about 25%, the amount of plasma containing anti-Rh required annually is about $216 \times 10^6$. The amount collected at our centre between October 1986 and September 1987 was thus about one third of the total requirement for England and Wales. Since the population from which we obtained the anti-Rh was 3·4 million and the total population of England and Wales is about 50 million, the amount of anti-Rh which could be obtained annually as plasma by measures similar to those we have adopted can be estimated to be $1 \times 10^9$ IU, or five times the total requirement for England and Wales when anti-Rh immunoglobulin is given only postnatally. This amount would in fact also be sufficient for routine antenatal immunoprophylaxis, assuming that two doses of 500 IU are given antenatally to all previously unimmunised Rh-negative women. In fact there would be more than enough anti-Rh immunoglobulin if the two doses given antenatally were reduced to 250 IU (50 μg) each.

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## Brief intervention by general practitioners against smoking

SIR,—The study by Dr M A H Russell and others (14 November, p 1240) indicates that brief intervention by a general practitioner with smokers is no more effective than doctors' usual care and that more intensive intervention is required. This is

contrary to earlier work by the same group,[1 2] though these past results are said to be due to the use of a no treatment control group. General practitioners are being asked to deal increasingly with their own patients' drug use, particularly of alcohol and tobacco, and the advocacy of brief therapy has helped to dispel some of their concerns about unmanageable workloads. The results of this paper need to be dealt with cautiously so as not to negate the value of brief therapy in general.

Firstly, perhaps an explanation of these findings can be found by looking at the concept of dependence. With alcohol, clients who exhibit low levels of dependence respond well to brief therapy, the more dependent drinkers requiring more intensive therapy.[3] Dependence on nicotine can develop rapidly and it is safe to assume that the smokers in this study were dependent. The results are thus comparable to those found with alcohol.

Secondly, the nature of the intervention is important. Self help manuals used for alcohol tend to be fairly detailed and include exercises leading to the patient making informed decisions about drug use after considering the costs and benefits of various options. This contrasts with the advice to patients in this smoking study simply to stop smoking. In addition self help manuals usually contain exercises on self monitoring, identifying and coping with high risk situations, and dealing with relapse. It would be worth contrasting these manuals with the leaflet described by Russell and his colleagues. One study[4] showed that the accurate empathy of the therapist conducting brief interventions was predictive of success, and I wonder if advice to smokers to stop smoking is sufficient to communicate such empathy.

The work of Russell and his colleagues has inspired much endeavour. I sincerely hope that the latest paper is seen as reflecting the difficulties inherent in dealing with smokers and not as an indictment of brief interventions per se.

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## Teaching general practitioners

SIR,—The situation in which Dr M N J Ruscoe finds himself in Cornwall (7 November, p 1175) is very different from the situation here. As general practitioner tutor for North Birmingham, I have an active committee which helps me to plan the regular weekly general practitioner meetings. The committee consists of a past general practitioner tutor, the present tutor, two interested general practitioners (one of whom is a member of the Royal College of General Practitioners faculty board), a new principal, and a dentist. If I cannot chair a meeting myself a member of the committee is always willing to stand in for me.

The clinical tutor at Good Hope General Hospital has delegated general practice education in my direction. So far I have not really required his help in organising a suitable programme for our meetings. It is, however, nice to know that he is available should I need to consult him. My job is made much easier by the enthusiastic help I have from the secretarial staff in the postgraduate medical centre.

I feel that the solution recommended by Dr Ruscoe of combining the work of the general practitioner tutor with the tasks of the team of course organisers is not viable. Teaching existing general practitioners, some of whom are very set in their ways, is a very different matter from teaching young energetic trainees.

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## Children born near Seascale

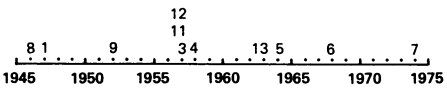
SIR,—It is not clear how Dr Richard Wakeford's latest presentation of the Sellafield data adds to the current debate over their interpretation (21 November, p 1347).

One of the questions at issue is the possible connection between leukaemia and exposure in utero to radioactivity discharged during the 1957 Windscale fire (24 October, p 1066). In concentrating exclusively on the 0-15 year age group in Seascale village alone Dr Wakeford's tabulation omits three children identified by Sir Douglas Black as having died from leukaemia in the immediate area and as likely to have been in utero at the time of the fire.[1] One patient (case 4, diagnosis at age 20) was born in Seascale, whereas the others (cases 11 and 12) were born elsewhere in Millom rural district (diagnosis at age 16 and 11 respectively).

Firstly, the restriction of Dr Wakeford's analysis to the 0-15 year age group belies the existing uncertainties over the carcinogenic effects of prenatal irradiation. Laboratory work is still in its infancy,[2] while human population studies leave unresolved the question of the age at which excess risk may be greatest.[3] Empirical data ought not to be excluded on the basis of assumptions the validity of which remains to be established.

Secondly, given the raised incidence of leukaemia in young people in Millom as a whole,[1] Dr Wakeford's omission of cases outside Seascale must be queried. Case 2 in Dr Wakeford's tabulation, however, should have been excluded, since this child was born outside the district in question and therefore could not have been affected in utero by radiation from the plant.

The amended tabulation is shown in the figure and draws on the original data presented in figure 2.2b of the Black Report.[1]




Year of birth of cases of leukaemia in young people (aged 0-24 at diagnosis) born in Seascale and Millom district.

Dr Wakeford further points to the different age distributions for leukaemia in the young populations of Seascale village and Millom district. There remain many questions about the patterns of child cancer around nuclear installations. Some of the issues will never be resolved to fully Popperian specifications. Nuclear installations in the United Kingdom have been discharging a very large number of radionuclides in different quantities over a very long period via both marine and airborne routes, and as a result Dr Wakeford should expect neither uniform patterns nor universal explanations.

The incidence of child leukaemia in Seascale is undeniably exceptional.[4] Dr Wakeford has repeatedly insisted[5-8] that any causal explanation must account for the apparent limited geographical confinement of the cancer excess to Seascale and not to other coastal wards. This argument is undermined, however, by the evidence of a raised incidence in these areas of child cancers other than leukaemia. There are 675 electoral wards in the north west of England. When ranked by Poisson probability for the incidence of child cancer, four of the top 10 wards are found to be on the Cumbrian coast (Seascale, Wampool, Bootle, and Barrow Island). Urquhart and Cutler calculate that the probability of such a distribution occurring by chance is less than 1 in 700.[9]

Of course, there remain uncertainties and ambiguities in the epidemiology. As I pointed out, however, the margins of error in the radiobiological calculations in the Sellafield risk assessment are extensive (24 October, p 1066). Dr Wakeford scrutinises the epidemiology while neglecting the problems of radiobiological theory. Implicit in this position—and in that of the Black Report—is a paradox: should the epidemiological evidence grow stronger the greater would be the disagreement with radiobiological theory, and therefore the less likely should be any connection with radiation. Since this paradox was first pointed out,[10] several studies have uncovered possible raised risks of child leukaemia around nuclear installations.[10-12] Thus the paradox is now acute.

Dr Wakeford is in danger of missing the wood for the trees. Given that the pattern of child cancer around Sellafield is most unlikely to have occurred by chance, that it manifestly could have been caused by ionising radiation, and that we know of no other cause, then it would seem at least prudent to give the benefit of the doubt to the local populace and not, as it has been, to the nuclear industry.

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## Medical confidentiality in child sexual abuse

SIR,—A recent case raised even more complex issues than those mentioned by Dr Roger Williams and his colleagues (21 November, p 1315) in their article on child abuse.

A 14 year old girl of Asian origin, unhappy in school and taking analgesics for vague complaints, had told a teacher in strict confidence that she had been sexually abused about four years previously by an uncle who had claimed to have sexually abused other young girls and now had teenage daughters of his own.